State of Colorado COBRA Election

NOTE: You have 60 days to elect to continue your current coverage through COBRA

Employee Social Security #	Emp. Last Name	Emp First Name	Primary Phone #	Department Name

Mailing Address	City	State	Zip	E-mail Address

	LAST NAME	FIRST NAME	SS #	Gender	Date of Birth	Medical	Dental	FSA (MEDICAL)	Enter the Name of the MEDICAL/DENTAL PLAN you had as an ACTIVE employee
Emp				☐M ☐F		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Spouse				☐M ☐F		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Dep-1				☐M ☐F		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Dep-2				☐M ☐F		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Dep-3				☐M ☐F		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Dep-4				☐M ☐F		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	

☐Termination/retirement 18 Months	☐Disability Retirement/Termination 29 Months (Proof of disability required)	☐Reduction of work hours 18 Months	☐Death of employee 36 Months (affects dependents only)	☐Divorce or legal separation 36 Months	☐Child losing eligibility 36 Months	☐Employee electing Medicare as primary 36 Months (affects dependents only)

AGENCY USE ONLY	Date of Qualifying Event	Date Current Coverage Ends		
DPA USE ONLY	COBRA Eligibility Begins	COBRA Eligibility Ends	Date Sent to Carriers(s)	Date Sent to Participant

COBRA Statements & Signature (MUST be signed and dated)

It is understood and agreed that the above information is true and shall be the basis for the issuance of the coverage(s) applied for, and that the omission or misstatement of any material information shall void this application for coverage. I/We authorize, by my/our signature(s), any physician, hospital, clinic or other organization or person to release to the appropriate medical and/or dental provider(s) or its representative(s), all medical and/or dental records which the latter may require for the purpose of evaluating the delivery of alternative methods and utilization of health care services appropriate to any health condition. I/We further agree that my medical and or/dental carrier has the right to cancel my/our coverage in the event that I/We fail to cooperate in providing the company with these records or if I/We fail to pay the premium(s) within the required time period. A photographic copy of this authorization shall be as valid as the original. I/We hereby certify that **If this election is being made due to a divorce please provide an accurate address.**

Employee Signature: **Date:**

Dependent Signature: (Check one) ☐Spouse ☐Former Spouse ☐Child Date:

(Must be signed if applying for coverage on his/her own)

COBRA Election Form Instructions

Please review your election notice for information regarding your rights and responsibilities.

HOW TO COMPLETE THIS FORM:

- The first two rows are for information pertaining to the employee. This is required to verify coverage.
- List all eligible persons to be covered under COBRA.
- Check yes or no for each individual electing "medical", "dental," "FSA" (Medical only, & employee only), check if "Enrolled in Medicare,"
- Enter the name of the medical/dental plan you had as an active employee.
- If you are electing COBRA due to a divorce please attach another piece of paper with the correct mailing address.

Qualifying Events/Date & Length of Coverage

- Check the qualifying event that applies to your situation. The number of corresponding months of eligibility is located next to the qualifying event. Enter the Qualifying Event Date on the line next to your Qualifying Event selection.

COBRA Statements & Signature

- Read this paragraph carefully.
- The spouse/former spouse, if applying for continuation of coverage on his/her own, must check the appropriate box (spouse or former spouse) then sign and date this form on the appropriate line.
- A dependent, if applying for continuation of coverage on his/her own, must sign and date this form on the appropriate line.
- Make a copy of this election form and keep for your records. Return original to
  Department of Personnel & Administration
  1313 Sherman Street, First Floor
  Denver, Colorado 80203-2244

- For More Information
  If you are unsure of your rights and responsibilities under the law or need assistance in completing this form contact the Department of Personnel & Administration COBRA Coordinator at 303-866-3434 or 1-800-719-3434.

Billing

- Medical/Dental: After processing of your application for continuation of coverage(s) through COBRA, you will receive monthly billings directly from the appropriate medical and/or dental carrier(s). **DO NOT SEND MEDICAL AND/OR DENTAL PAYMENTS TO THE Department of Personnel & Administration.**

- Health Care Flexible Spending Account: if you elect to continue your Health Care Flexible Spending Account, you will not receive a formal bill. Payment for your current monthly contributions must be sent directly to: Department of Personnel & Administration
  1313 Sherman Street, First Floor
  Denver, Colorado 80203-2244

Fraud

- It is unlawful for any employee, employee's dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application for benefits or claims for benefits. Penalties may include imprisonment, fines, denial of enrollment in any or all of the state's benefit plans, civil damages, termination of participation in any or all of the state's benefit plans, or as provided in regulations, statues, and written directives.